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SUICIDE ATTEMPTS

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U. S. NAVAL AEROSPACE MEDICAL INSTITUTE  
U. S. NAVAL AVIATION MEDICAL CENTER  
PENSACOLA, FLORIDA

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## SUICIDE ATTEMPTS

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## SUMMARY PAGE

### THE PROBLEM

One out of five psychiatric patients whom a military physician sees will have a suicidal component to his problem. The suicide gesture is frequently a dramatic mode of communication. In the military, the latent content of this communication is most often, "Please help me get out of the service, I can't stand it any more." With the intention of clearly delineating those persons who express their discontent through a suicide gesture, all patients at the Naval Aviation Medical Center who had made such a gesture in a 9-month period were retrospectively studied. These persons were compared on 35 demographic, historical, and clinical variables with 1) randomly selected psychiatric patients and 2) well-adjusted enlisted men. Follow-up studies were made on all except the well-adjusted group.

### FINDINGS

The most important single finding of the large amount of data gathered is the success of persons who make suicidal gestures in manipulating their environment. Although 83% of this group were returned to duty, with the expectation that they would remain there, at the time of the follow-up 48% had obtained premature discharge from the military by other means; this was true of only 8% of the psychiatric controls. Those 48% also showed statistically significant differences in histories of more impulsive behavior, civilian legal offenses, poorer peer and authority relations. The suicide attempt group could not be differentiated statistically from the psychiatric control group; however, both of these groups differed significantly from the well-adjusted group with regard to showing more civilian legal problems, impulsive behavior, conflict between parents, poor relations between fathers and patients, and poor peer and authority relations. These are characteristics often attributed in previous uncontrolled studies to suicide attempters alone. Repeat suicide attempts were rare.

This study highlights two important facets of the make-up of persons who attempt suicide: 1) the intensity, urgency, and necessity of the patient who makes a suicide attempt in resolving his perceived conflict, and also, interestingly, his success in this endeavor; and 2) the lack of contact he perceives with his peers and, inferentially, his intense isolation. This study also provides clear clinical criteria for the evaluation, treatment, and disposition of these patients by the military psychiatrist. Due to the age and sociologic setting of the present sample, the data are generally applicable to other total institutions, e.g., boarding schools, colleges, residential treatment centers, et cetera.

## INTRODUCTION

Suicidal behavior, whether it be maximally or minimally successful, is a dramatic and perplexing event. Intermingled with the medical problems of suicidal behavior are concomitant legal, moral, and, in the military, administrative issues. An actual suicide offers no immediate problem with regard to medical management and disposition; however, the physician is frequently confronted with such patients as the unrequited lover or the adolescent who had an argument with parents and had ingested several nontoxic pills with great fanfare. In the military, the most frequent image of the suicide attempter is that of a gangling, ravaged, late adolescent with a bleeding wrist who states that he is presently extremely unhappy and that the only way he can become happy in the future is by immediate separation from military life. These patients who have made minor attempts raise many questions for the responsible physician and enmesh the doctor in legal, moral, and administrative issues.

Salient to many suicide attempts, particularly in younger populations, is the fact that these people are not seeking death, itself, but are attempting more to relate or communicate to their environment. Suicide has been characterized as having a "Janus faced quality," (13) with one face directed at life and the other at death. In the military population, it is the face toward life that is most prominent. There is a clear distinction in the literature between those who make suicide attempts and those who actually commit suicide (2,7,10,12). The actual suicide is most frequently a male, forty to sixty years of age, in poor health, depressed, widowed or separated from his wife, who has usually shot himself or used other violent means; whereas, the typical attempter is most frequently a female in the twenty- to thirty-age range, in good health, with marital difficulties, who has ingested some barbiturates. Characteristic of the suicide attempter is a lack of profound depression; the vegetative and self-deprecating qualities of the markedly depressed are absent. Central to his problem is the question of aggression and anger. It is not the internalized anger of the depressed, but more the outwardly directed anger of a person "acting out" his conflicts, lashing out at the environment.

The environment of the young person entering the military is new. He is confronted with an authoritarian environment having strict lines of communication, and he is also thrust into a role for which he may not be prepared. Loyalty, obedience, and teamwork, the criteria of success in the military environment, may also act as stressors to the person entering the service. The military physician sees many physical and somatic reactions to the stresses of this new environment, but none as dramatic as the suicide attempt.

The military allows a unique setting in which to study suicide attempts; as a closed and self-contained environment, it affords an excellent opportunity to investigate both the premorbid environment and the individual's adjustment to this environment. Similarly, both the environment and the patient are available for study after the suicide attempt, as are clear-cut criteria for adjustment to the military environment.

It is the purpose of this study to 1) evaluate suicide attempts by military personnel by clearly defining a large group of patients who have made such attempts, 2) determine the significance of the suicidal act in the military, and 3) clarify the management of these patients.

## PROCEDURE

The population encompassed three distinct groups from the same nine-month period: 1) Forty-two patients who had made a suicide attempt and who were either hospitalized on the psychiatric ward or seen in the psychiatric out-patient clinic of the U. S. Naval Aviation Medical Center. This group will be subsequently referred to as SA, or suicide attempters. The only criterion of selection was a definite suicide attempt: no patients who had made suicide threats were included. (The greater proportion of hospitalized patients does not connote seriousness of attempt, but rather, administrative policies, in that physicians at outlying commands admit directly to the hospital, and there is no screening of admissions by psychiatrists.) 2) Twenty randomly selected psychiatric in-patients who had not made a suicide attempt, most of whom were also seeking environmental change; these are referred to as the psychiatric patient control group, or the PPC group. 3) Thirty well-adjusted Naval enlisted men who were seeking change in their environment and were seen for a routine psychiatric screening as applicants for Submarine School, Antarctic duty, et cetera; these comprise the well-adjusted controls, or the WAC group. All information was gathered retrospectively from the hospital charts and a standardized psychiatric questionnaire used by our department. The raw nominal data (Appendix A) were subjected to chi-square analysis. In the text and most of the tables the nominal data are expressed in percentages for ease of comparison. Due to the small subject sample the Fisher Exact probability test was used in compilation of the follow-up data on the SA group.

## RESULTS

### INCIDENCE

During the nine-month study period, 17 per cent of the psychiatric hospital population had made a suicidal attempt. In the same time period, 5 per cent of the psychiatric out-patients had made a suicide attempt. Incidence of such attempts at U. S. Navy psychiatric treatment centers varies from 15 per cent (3) to 36 per cent (5). These data deal only with actual attempts; the incidence of threats has been substantial. It has been stated in the past (3,8,14) that suicide attempts are more common in the military than in civilian life. Due to differences in reporting rates, it is difficult to compare the incidence of suicide attempts in the military to any civilian data. One would expect to have a higher incidence of suicides in the military, primarily due to the fact that the physician is more accessible, better records are kept, and, also, psychiatric consultation is frequently more available. When any patient sees a doctor in the military, a record is made of this. In civilian life, certainly many suicide attempts are disguised, seen by family physicians, and not reported. The exact incidence of suicide is difficult to

determine, due to variances of reporting suicide as such. Frequently, a patient who has made an attempt and is hospitalized will be signed out as a depressive reaction, with no mention of suicide. Certainly, in the population of the present study, some patients may have been dealt with at a local level; and also, some of the numerous auto accidents may have been disguised suicide attempts. However, it is felt that the incidence of somewhere in the area of 20 per cent is probably a valid figure for the military situation. The military medical officer can then expect that at least one in five patients with psychiatric problems whom he sees will have a suicidal component.

## DEMOGRAPHY

The three populations studied were similar with regard to age, education, rate, and length of service although the SA group did include a greater number of patients under twenty-one years of age (Table I). This finding is consistent with other studies of attempted suicide (3, 11, 15, 16). Although suicide is not a disease of young people, it is a frequent form of self-expression in adolescent and early adult populations. It is of note that actual fatalities from suicide, or due to suicide, have been reported as greater in the group over forty-five years of age (12).

Table I  
Demographic Distribution of Subjects

	SA (N=42)	Groups PPC (N=20)	WAC (N=30)	p*
Mean age	20.9	24.7	23	
<21 years	81%	60%	34%	.001
>21 years	19%	40%	66%	
Military rate (avg.)	E3	E3	E3	
Education (yrs.)	11.1	11.3	11.0	
GCT (avg. score)	55	+	52	
Length of service				
<21 years	12.2 mo.	9.3 mo.	19.0 mo.	
>21 years	7.3 yr.	11.1 yr.	8.0 yr.	
Married	26%	30%	50%	

\*Chi square on raw nominal data, Appendix A

+ Data not available

Suicide frequently has been typified as a disease of social isolation. In this respect, it is interesting that the well-adjusted group had a greater proportion of married people than the other two populations. This may not be significant, as frequently it has been noted that, in general, psychiatric patients include a great number of single people.

In none of our three groups were there any officers. In the two patient populations, this can probably be explained by selection criteria. All officers are either college graduates or former enlisted men with six to eight years of exemplary service, factors which would tend to screen out symptomatic psychiatric problems.

## DIAGNOSIS AND SYMPTOMS

Consistent with the stereotype noted in the Introduction is the finding that 65 per cent of the SA and PPC groups were diagnosed as having characterological or personality disorders (Table II). The relative absence of major psychotic reactions and schizophrenia is consistent with military psychiatric practice in general. Although depressive diagnoses were slightly more frequent in the SA group, they were conspicuously in the minority in the SA and PPC group. Due to the composition of the population studied which was a military population with many characterological problems, the data should not be interpreted as indicating that suicide attempts are not related to major psychotic reactions. Suicide is frequently associated with psychotic and involutional depressive disorders (7, 10) as well as with schizophrenia; however, in the present population, suicide attempts did not seem to be related to the classical major psychopathological syndromes.

Table II  
Diagnosis and Symptoms

	Group	
	SA (N=42)	PPC (N=20)
Diagnosis	Per Cent	Per Cent
Characterological or personality disorder	65	65
Depressive	20	2
Situational	14	25
Schizophrenic	4	2
Symptoms		
Depressive )	40	15
Angry ) - Affect	2	5
Hostile )	10	15
Sleep	17	25
Appetite	14	30
Thought Disorder	5	5
Motor	17	30
Anxiety	40	80
Manipulative	43	40
Immature	14	45

The symptomatology noted confirms the above speculations. Although there was a preponderance of depressive affect noted in the SA group, it was surprisingly small. It indicates that the suicide attempts seen in the military are related to things other than depression. The comparative lack of symptomatology of a vegetative nature (sleep, appetite disturbances, et cetera) would also indicate a process in the SA group unrelated to ego dystonic actions, and more related to ego syntonic modes of functioning.

The PPC group exhibited more symptoms, and certainly more anxiety, than the SA group. In fact, clinically, the PPC's appeared to be the more agitated and emotionally ill group of patients.

### PRECIPITANTS TO ADMISSION

In the SA group the suicide attempt itself was a prime factor in these patients either being seen or hospitalized. The factors leading to the admission of the PPC's varied from anuresis to violent assaultive behavior.

In both of these groups, the chief complaints, or what the patients cited as the main causal factors in their present state (Table III), were primarily expressions of dissatisfaction with the Navy, or their assignments in it. The complaints about sexual matters were usually centered around some trouble with a female or the difficulty of meeting females and frequently were coupled with these complaints about the Navy. Even the attributing of part of their present mental state to familial problems seemed to relate somewhat to the Navy. It was frequently stated that, due to problems at home, they, the patients, were needed, and consequently felt helpless or worth more dead, or that their wives were so unhappy about their duty or coming transfer that suicide was the only solution. Few of the admissions to the hospital groups were related to either drinking or homosexuality.

Table III  
Percentage Distribution of Precipitants to Admission

	Group		P*
	SA	PPC	
	Per Cent	Per Cent	
Patient's perception of precipitating events			
Navy	74	50	.10
Sex	55	10	.001
Family	47	20	.20
Endogenous (Psychosis)	4	0	
Prior thought about suicide	14	0	
Drinking prior to admission	4	5	
Homosexual problems	7	15	

\* Chi square on raw nominal data, Appendix A



Conspicuous by its absence was the lack of planning and forethought relating to the suicides. There was only one suicide note in the entire SA sample, and this was by one of the two schizophrenic patients. The greatest proportion of the attempts seemed to be of an impulsive nature. The mode and setting of the attempt revealed some of the communicative aspects of the act.

#### MODE OF SUICIDE ATTEMPT

The SA's could be divided into two subgroups based on their premorbid behavior and mode of suicide attempt: 1) those who had initially seen their local medical officer about "nervousness," and 2) those who had not been in contact with medical officers. As can be expected, drug ingestion was the most popular mode and was that used by one-half of those attempting suicide. In almost all of these cases, the patients were admitted to psychiatric service after they had communicated to their own medical officers the fact that they had ingested pills. The slight consequence of these attempts is demonstrated by the fact that almost none of these patients were comatose on admission. The most commonly used medications were analgesics (aspirin, Darvon, et cetera), but a surprising number of patients used small amounts of tranquilizers. Most of these medications had been obtained from their medical officers who had prescribed medication for the patients' minor complaints or vague nervous symptoms. Very few of these patients had openly expressed their dissatisfaction with the Navy to these medical officers. Only after their attempt at suicide was this evident.

The second group, totaling eighteen, comprised mostly "wrist slashers" and, interestingly enough, only two of these patients had had contacts with a physician prior to the suicide attempt. They were reported to medical officers by intermediaries, i.e., division chiefs, brig guards, et cetera. Three attempts were of a dramatic nature, i.e., by shooting, jumping off a ship, and hanging. Again, none of these constituted a life threatening attempt. In spite of the distinction noted, it was not possible to detect any statistically significant differences on any of the variables surveyed when these patients were grouped by these distinctions. However, of those who were returned to duty and ultimately discharged for disciplinary reasons, 75 per cent were wrist slashers, which may indicate not only a greater impulsivity inherent in these patients, but more communicative difficulties and a greater intensity of their need to manipulate their environment.

#### PAST MEDICAL AND PSYCHIATRIC HISTORY

Patients in the SA group were the only ones who had had any prior psychiatric contacts and also the only ones who had had any prior suicide attempts. Seven members of the group had attempted suicide previously and nine had had prior psychiatric treatment. Repeat suicide attempts are not uncommon, and it is not surprising that those who have had a history of suicide attempts would be included in the SA group.

## SOCIAL HISTORY

Marked differences noted between the SA group and the other two groups lie almost exclusively in the social sphere. Few patients in the SA group had stable work histories, and good peer or authority relations, whereas in both control populations, the converse was significantly apparent (Table IV).

Table IV  
Percentage Distribution of Social History Factors

	Groups			P*
	SA	PPC	WAC	
	Per Cent	Per Cent	Per Cent	
Work history				
Stable	31	65	80	.001
Unstable	26	25	7	.10
None	43	10	13	
Legal difficulties				
Civilian	31	40	7	.01
Military	47	40	23	.20
None	12	20	70	.001
Peer relations				
Good	14	75	63	.001
Bad	40	25	20	.20
Authority relations				
Good	19	55	83	.001
Bad	52	40	17	.01
Impulsive behavior history	68	60	13	.001

\*Chi square on raw nominal data, Appendix A

The fact that the SA and the PPC groups had a high incidence of civilian legal difficulties is consistent with the high number of character disorders in each group; however, it is surprising there is no statistical difference in the number of military legal difficulties in the three populations. As would be expected, the WAC group had much better impulse control than both psychiatric populations.

## FAMILY HISTORY

Familial chaos frequently has been cited as a contributing factor in patients who have made suicide attempts (4, 15, 16). In the present study, this did not appear to be true of the suicide attempters specifically, but rather of those having psychiatric difficulties in general. This is an interesting finding in itself, and shows the necessity of having control populations, since studies citing familial disruption frequently have been uncontrolled. Due to the emphasis placed on family relationships in studies of suicide attempts, the SA group was studied extensively by various groupings within this variable. The SA group were divided according to 1) whether the nuclear family was separated or together, 2) the relationship between the parents, and 3) various combinations of parental relationships to the patients (Table V). In none of these groupings was there any clear pattern of symptoms, diagnoses, or other variables which achieved statistical significance. However, this may be related to the size of the sample, and a larger sample might reveal more statistical differences.

Table V  
Percentage Distribution of Family Histories

	Groups			P*
	SA	PPC	WAC	
	Per Cent	Per Cent	Per Cent	
Family history of				
Suicide	7	5	0	-
Mental illness	28	20	0	-
Place in sibship				
First	70	45	50	.30
Middle	17	20	30	
Last	13	35	20	
Parents				
Together	67	35	60	.40
Separated or divorced	33	65	35	.40
Parental relationship				
Kind and loving	40	45	60	.30
Fighting	45	40	3	.001
Relationship to mother				
Positive	54	65	73	.20
Negative	40	50	23	.20
Relationship to father				
Positive	38	40	87	.001
Negative	55	55	10	.001

\*Chi square on raw nominal data, Appendix A

The inability to distinguish the SA group from the PPC group with regard to family history is striking. If we compare the SA and PPC group to the WAC, it is evident that the former two groups gave histories of more fighting between the parents; they also perceived their relationships to their fathers as worse, a factor which would be indicative of poor relations with male authority figures in general. The sparseness of a family history of mental illness and familial suicide would also tend to mitigate any argument attributing suicidal behavior to a learning process in the home. It is of note that first children predominated in the suicide sample. This finding has been noted in one other study (16) and the authors speculated about its relation to the feelings of rejection experienced by first children at the birth of subsequent children; however, it is a finding that is difficult to explain.

## HOSPITAL COURSE AND DISPOSITION

As seen in Table VI, the two patient groups were remarkably similar on these variables. The slightly greater average time spent in the hospital by the SA group was due primarily to the fact that two of the three patients with schizophrenia were in the SA sample, but also because patients who were transferred to treatment centers required a longer time for administrative processing. When a prognosis was given, it is noteworthy that fewer prognostic comments were made by the psychiatrist about the suicide group. This may reflect some confusion and uncertainty on the part of the psychiatrist about the future adjustment of these patients who complained so bitterly, primarily about the military environment as a factor in their illness. It is also significant that at least 75 per cent of each patient group gave lip service to the decision to return them to duty, which, in most cases, was the disposition.

The disposition of the two patient groups was similar although a greater number were initially discharged from the PPC group. This is more related to administrative policy regarding patients with enuresis, homosexuality, et cetera, receiving mandatory discharges than to actual severity of their illnesses.

**Table VI**  
**Course of Treatment and Disposition**

	Groups		
	SA	PPC	WAC
Days in hospital	20.3 days	15.9 days	0
Received drugs	14%	15%	0
Mutuality about disposition			
No	23%	25%	0
Yes	77%	75%	0
Prognosis			
Good	14%	40%	
Bad	21%	60%	
None given	65%	--	
Disposition			
Return to duty	60%	60%	0
Return to duty - qualified	23%	20%	0
Discharged from service	9%	20%	0
Transferred to treatment center	8%	0%	0

## MANAGEMENT AND CLINICAL ASPECTS

In general, patients in both the SA and the PPC groups were managed similarly, e.g., 1) clarification of feelings and situations; 2) reality confrontation; 3) the setting of limits; 4) rapid return to duty with advice to patients' immediate superiors in regard to management. This form of management of suicide attempters in the military has been noted previously (6); however, it is of interest that in one study (3) of suicide attempts in the military, most of the patients were immediately discharged. The actual management depends upon individual philosophy, and there is no rigid military policy; however, we believe that, since most of these patients have characterological problems and evidence their difficulties by acting out, it is best to manage them in a manner which would aid them to complete something and would limit the acting out, perhaps for the first time in their lives.

Although there were no statistically significant groupings of the SA group possible, three clinical types did seem to be evident. The first which may be typified as "out at any cost" seemed to be made up of patients who made it quite clear that their only salvation would be separation from the military, as this was the main cause of their problems. Other than this, it was difficult to get any information from these patients about the etiology of their current upset. The following patient fell into this category:

A twenty-one year old Airman, U. S. Navy, with six months' active duty, was admitted to the hospital complaining of headaches and nervousness after a minor head injury two and one-half weeks previously. He was also awaiting Captain's Mast for missing a watch. He stated, "The Navy has made me nervous; I am not my happy-go-lucky self." There was a marked past history of truancy, arrest, and job instability. After evaluation and clarification, the patient was returned to duty in the midst of great protest and threats about the harm that the Navy would do him. Shortly after return to duty, he attempted to hang himself in the brig aboard the ship and was returned to the hospital. Due to the patient's past history and apparently low frustration threshold, he was medically discharged from the service.

The next major clinical type seen can be classified as the "help group." This patient is typically young; he joined the service mainly in search of identity, adventure, to see the world, or to get away from home. He has usually done well in boot camp, as he expects this is only the prelude to the "big, wonderful world"; however, when he gets to his first duty station or ship and finds it markedly mundane and different from his fantasies, he becomes disillusioned and depressed and begins to question his suitability for the service, and even life itself. An example of this type of patient follows:

A twenty-year old Seaman, U. S. Navy, with eleven months' active duty, was admitted from a training school after he had ingested six Ritalin tablets. He reported immediately to the dispensary after which he was admitted to the hospital. Past history revealed that he had had some civilian out-patient psychiatric treatment at fourteen years of age because he could not "get along with his parents." He joined the Navy to get away from home and to "make something of himself." He had been in many minor, military disciplinary difficulties, but none as a civilian. After breaking up with a girl friend and receiving a letter from his mother, he began to feel that he was "falling apart" and sought some aid at the local dispensary, where he had been given the medication. He did not attribute his problems specifically to the Navy, but to his "not fitting in anywhere." After some psychotherapy, some of his romantic expectations were clarified, as well as some of his questions about his own identity, and he was returned to duty.

The third type commonly seen may be classified as "life's problems." This type of patient is more typical of those seen in civilian practice where the suicide attempt is frequently a gesture to re-establish some interpersonal relationship; it is usually unrelated to the military environment. This type is more common in the older age groups of the military population of this study; an example follows:

A twenty-seven year old Third Class Petty Officer, U. S. Navy, with eight years' active duty, was admitted to the hospital after slashing his wrist with a razor in front of his wife. He stated that he and his wife had been drinking and had begun to argue. His wife had said that she was leaving him. He then made the suicide attempt and was hospitalized. He and his wife were seen in consultation, and the patient was returned to duty after a resolution of some of the problems. He was to be followed as an out-patient. There were no marked depressive symptoms or psychiatric symptoms of any nature other than impulsivity and some immaturity.

Although the patients in the SA group seemed to fall into clinical types, initially, they gave little guidance to the adequacy of treatment or disposition. It was in the follow-up of the two patient populations that clear guidelines about the suicidal patient and the implications of the attempts, as well as a classification of the SA's, became apparent.

#### FOLLOW-UP

This was the most revealing area of the entire study. Up until then we had not been able to differentiate clearly the patients in the SA group from those of the PPC group, and we had gained little insight into any variables peculiar to patients who attempt suicide. Although 83 per cent of the SA group had been returned to duty (Table VI), at the time of follow-up nine to eighteen months after initial contact, 48 per cent had been separated from the service prior to the end of their enlistment for other than psychiatric or medical reasons, usually of a disciplinary nature. Significantly, this 48 per cent came exclusively from the group that was unqualifiedly returned to duty. A similar proportion of the PPC group (80 per cent) had been returned to duty, but only 8 per cent had been prematurely separated from the service at time of follow-up. In all, 67 per cent of the SA group had been prematurely discharged from the military, while only 35 per cent of the PPC group was discharged early. Repeat suicide attempts were rare in those out of military service (4 per cent,  $N = 1$ ), as was psychiatric rehospitalization of these patients (4 per cent,  $N = 1$ ) (Table VII). These findings are consistent with those of another study (1).

Table VIII summarizes the findings of the 42 patients in the SA group. Based on the follow-up study these patients are grouped according to: 1) those who returned to duty and remained on duty; 2) those returned to duty, but who obtained premature discharge; and 3) those immediately discharged. Statistical differences can be noted.

Those who immediately or ultimately were prematurely separated from the service clearly evidenced more impulsive behavior, civilian legal problems, and poor peer and authority relations.

Table VII

Follow-Up of Suicide Attempters Out of Service  
(N = 28 - 67% of sample)

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Saw problem as psychiatric one

Yes - 36%  
No - 42%  
Uncertain - 22%

Effect of Psychiatric care

Good - 50%  
Bad - 21%  
Indifferent - 29%

Work history

Stable - 50%  
Unstable - 42%  
Prison - 4%  
Unknown - 4%

Trouble

Yes - 43%  
No - 57%

Psychiatric rehospitalization - 4%

Repeat Suicide - 4%

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Table VIII  
Follow-Up of 42 Patients Who Attempted Suicide

	To Duty Remained in Service N = 14	To Duty Out of Service N = 12	Out Initially N = 16	P = Fisher Exact Probability
Age (average)	20	19	20	
<21	11	10	13	
>21	3	2	3	
Rate	E3	E3	E3	
Length of service				
<21	14.7 mo.	9.0 mo.	11.0 mo.	
>21	10.0 yr.	8.0 yr.	10.0 yr.	
Married	4	4	3	
Highest grade of schooling	11	10	11	
Disciplinary problems				
Civilian	1	7	5	*
Military	6	6	8	
Impulsive acts	7	11	11	*
Peer relations (Hx of)				
Good	5	0	1	*
Bad	3	7	7	
Authority relations (Hx of)				
Good	6	1	1	
Bad	4	9	9	*
Work history				
Stable	7	2	4	
Unstable	3	3	5	
Past history psych. problem	3	1	4	
Family history				
Parents together	12	6	10	
Separated or divorced	2	6	6	
Psych. problems	4	5	6	
Relations between parents				
Positive	7	4	6	
Negative	5	5	9	
Relation - patient to father				
Positive	7	2	7	
Negative	6	9	8	
Relation - patient to mother				
Positive	10	5	8	
Negative	4	6	7	
Place among sibs				
Oldest	5	9	1	
Middle	6	1	0	
Youngest	2	2	1	
Contributing factors				
Alcohol	1	3	0	
Homosexuality	1	0	2	
Patients view of problem (chief complaint)				
Navy	10	7	14	
Sex	10	6	7	
Family	9	8	3	
Days in Hospital	4	10	20	

\* = 0.05

## SUMMARY OF FINDINGS

The similarity of the suicide attempt group and the psychiatric in-patient control group on the demographic and dynamic variables surveyed is striking. Only three variables achieved statistical significance in differentiating the SA from the PPC group: 1) lack of good peer relations; 2) perception of the problem as relating to sexual matters; and 3) age under twenty-one years. The clinical psychiatric impression also confirmed the similarity between the two groups in that 65 per cent of the patients in each psychiatric group were diagnosed as having a characterological or personality disorder. Traditional depressive symptomatology, either of a vegetative or dynamic nature, was markedly absent from both of these groups; however, there was a distinct impression that the control group seemed more anxious and in more emotional distress than the suicide group. Clinically, both groups of patients were similar in that most of them looked to the psychiatrist for some aid in effecting a change in their reality situation, either by discharge from the service, change of present duty assignment, or in relationships with their families. Few in either group saw the problem as related to intrapsychic difficulties.

When the two patient groups are combined and compared to the well-adjusted group, we find a greater degree of differentiation in that the patients showed a higher incidence of preservice legal difficulties, impulsive behavior, conflict between parents, poor relations between patients and their fathers, and poor peer and authority relations. This is of interest, for these factors frequently have been attributed to suicide attempters alone; whereas, these data indicate that, for the population studied, they are related more to psychiatric problems in general than specifically to suicide attempts. However, the clearest differentiation of the suicide attempt group from the psychiatric control group is noted in the follow-up data.

## DISCUSSION

This study has been primarily of an empirical and phenomenological nature. We have been asking, "Who are these people who make suicide attempts?" The answer seems to be that they differ little from the person who has difficulty in the military in general (9). They are young; they have had life-long problems of a characterological nature; they generally have had difficulty with male authority figures, particularly fathers; they have been unsuccessful in most of their endeavors, primarily in the completion of their required schooling; and they are impulsive. This study highlights some key characteristics of the person who makes a suicide attempt: 1) the intensity, urgency, and necessity of the patient who makes a suicide attempt in resolving his perceived conflict and also, interestingly, his success in this endeavor; and 2) the lack of contact he perceives with his peers and, inferentially, his intense isolation.

Both the patient's verbal and nonverbal communications convey the same message: "Let me out." It is of note that 73 per cent of these patients stated this directly at admission; 67 per cent ultimately achieved discharge; and 48 per cent of these achieved it on their own after the psychiatric exit was closed to them, often at the expense of a

dishonorable discharge. This not only connotes the urgency of their need to get out of the service, but also points to a sense of isolation as well. There is no regard for society's opinion of them and no regard for their long-term future, only their need to get out. This intensity and urgency are communicated to the psychiatrist and, in part, may account for some of the pejorative references (3,6) in the literature to these patients, because the patient seems to put the whole burden of his life and happiness on the shoulders of the psychiatrist as the only one who can help him. That this is a misperception by both psychiatrist and patient is manifested by the large number of patients in our study who were prematurely separated without psychiatric blessing. The quality of these patients' relations to their peers would seem to justify their sense of isolation. In the entire suicide group, only six patients stated that they had good friends or got along well with their peers, either past or present. In those patients returned to military duty and who ultimately obtained premature discharge, none admitted good peer relations. It is also of interest that there was only one suicide note in the entire group; this was one of the two schizophrenic patients in the suicide sample. Most of these patients freely admitted that they did not want to die; in fact, it is surprising how little they mentioned death. Most said they wanted to do something about their situation, but didn't quite know how to go about it or who would help. The high incidence in the suicide group of complaints regarding their sexual difficulties and even the absence of homosexual relationships also attest to their isolation and inability to form relationships.

This study also provides clear guidelines as to who can be returned to duty and be expected to perform with some effectiveness. The patient who returns to duty with the main aim of obtaining discharge is clearly one with poor peer relations, a history of civilian legal difficulties, past difficulty with authority relations, and impulsive behavior. However, the critical factor would still seem to be absence of good peer relations and inability to form some relationships in immediate social context. Conversely, the one who seems to be able to return to duty is often the adolescent who has functioned marginally in civilian life, was never really in trouble, who joined the service in his search for identity, romance, adventure, or simply to get away from home, and becomes disillusioned, but who also has had the capacity to form at least a few relationships with his peers. This patient can usually be returned to duty after some clarification of the problem. Of those returned to duty and who remained in military service after the suicide attempt, only 30 per cent received critical comments from their superiors relating to their work and behavior.

The follow-up of the patients prematurely separated from the service was less encouraging. Well over 50 per cent of those contacted revealed the following: 1) They had achieved no stable job pattern and had been drifting from job to job; 2) they were presently or recently in some type of legal difficulty; 3) their psychiatric contact was seen as no particular aid; 4) they still saw their problem as related to the external world rather than themselves. This separated group, not surprisingly, then emerges as a very ineffective group, both in the military and society in general. It makes one wonder if these patients and society would not be better served by closer liaison with civilian mental health resources, particularly those geared for characterological problems such as some of the retraining camps or job corps facilities.

## CONCLUSIONS

The military setting provides a unique opportunity for the follow-up of the psychiatric patient. Not only is information about the patient's status after psychiatric treatment available, but the adaptive and maladaptive characteristics of his actions are also highlighted. In this study of suicide attempts in the military, the communicative nature of the suicide attempt is remarkably apparent. Seventy-three per cent of these patients stated directly at admission, "Let me out of the service." The fact that 67 per cent of these patients achieved this wish, and 48 per cent achieved it without psychiatric help, is a testament not only to the urgency and intensity of this need, but also to their skill in manipulating their environment. This finding is somewhat paradoxical, in the sense that the majority of these patients have shown evidence of life-long characterological problems and failure. The use of a control population of psychiatric patients, most of whom were also seeking environmental change, further highlights the intensity of the need of the suicide attempter to change his environment, as only 35 per cent of the control population was discharged, and only 8 per cent of these accomplished this without psychiatric aid.

The intensity of the suicide attempter's need to change his environment is coupled with a marked sense of isolation. The patient who makes a suicide attempt perceives himself as cut off from social and emotional contact with his peers. He sees himself as not only friendless, but also incapable of making friends, and this self-perception may be critical in the choice of the dramatic mode of suicide to communicate his needs. This was particularly true of the group of patients who obtained premature separation even at the expense of a bad conduct discharge. These patients not only evidenced poor peer relations, but showed more impulsive behavior, civilian legal difficulties, and poor authority relations. The patients who evidence these symptoms are not only a high risk group for performing further useful military service, but also do very poorly upon return to civilian life.

## REFERENCES

1. Batchelor, I. R. C., and Napier, M. B., The sequelae and short term prognosis of attempted suicide. J. Neurol. Neurosurg. Psychiat., 17:261-266, 1954.
2. Carstairs, G. M., Characteristics of the suicide prone. Proc. Roy. Soc. Med., 54:262-264, 1961.
3. Fisch, M., The suicidal gesture: A study of 114 military patients hospitalized because of abortive suicide attempts. Amer. J. Psychiat., 111:33-36, 1954.
4. Gould, R. E., Suicide problems in children and adolescents. Presented at Meeting of Association for Advancement of Psychotherapy, New York, Feb. 28, 1964.
5. Gunderson, E. K. E., Personal communication.
6. Offenkrantz, W., Church, E., and Elliot, R., Psychiatric management of suicide problems in military service. Amer. J. Psychiat., 114:33-41, 1957.
7. Oliven, J. F., The suicidal risk. New Eng. J. Med., 245:488-494, 1957.
8. Otto, U., Suicidal attempts made during compulsory military service. Acta Psychiat. Scand., 39:298-308, 1963.
9. Roff, M., Relation between certain preservice factors and psychoneurosis during military duty. U. S. Armed Forces Med. J., 11:152-160, 1960.
10. Schmidt, E. H., O'Neal, P., and Robins, E., Evaluation of suicide attempts as guide to therapy. J. A. M. A., 155:549-557, 1954.
11. Schrut, A., Suicidal adolescents and children. J. A. M. A., 188:1103-1107, 1964.
12. Shneidman, E. S., and Farberow, N. L., Statistical comparison between attempted and committed suicides. In: Shneidman and Farberow (Eds.), The Cry For Help. New York: McGraw Hill, 1961. Pp 19-48.
13. Stengel, E., Enquiries into attempted suicide. Proc. Roy. Soc. Med., 45:613-620, 1952.
14. Teicher, J. D., A study in attempted suicide. J. Nerv. Ment. Dis., 105:283-298, 1947.

15. Toolan, J. M., Suicides and suicidal attempts in children and adolescents. Amer. J. Psychiat., 118:719-724, 1962.
16. Tuckman, J., and Cannon, H. E., Attempted suicide in adolescents. Amer. J. Psychiat., 119:228-232, 1962.

## APPENDIX A

# APPENDIX A

## Raw Normal Data of Study Groups\*

	Suicide Attempters N = 42	Psychiatric In-patient Controls N = 20	Well- Adjusted Controls N = 30	P= Chi Square
Age (average)	20.9	24.7	23	
<21	34	12	10	▲
> 21	8	8	20	
Rate	E3	E3	E3	
Length of service				
< 21	12.2 mo.	9.3 mo.	19.0 mo.	
> 21	7.3 yr.	11.1 yr.	8.0 yr.	
Married	11	6	15	
Highest grade	11.1	11.3	11	
Disciplinary problems				
Civilian	13	8	2	‡
Military	20	8	7	
Impulsive acts	29	12	4	▲
Peer relations (Hx of)				
Good	6	15	19	▲
Bad	17	5	6	
Authority relations (Hx of)				
Good	8	11	25	▲
Bad	22	8	5	‡
Work history				
Stable	13	13	24	▲
Unstable	11	5	2	+
Past history psych. problem	8	0	0	
Family history				
Parents together	28	13	19	
Separated or divorced	14	9	11	
Psych. problems	15	5	0	
Relations between parents				
Positive	17	9	18	
Negative	19	8	1	▲
Relation - patient to father				
Positive	17	8	26	▲
Negative	25	11	3	▲
Relation - patient to mother				
Positive	23	13	22	
Negative	17	7	7	
Place among sibs				
Oldest	29	9	15	
Middle	7	4	9	
Youngest	5	7	6	
Contributing factors				
Alcohol	4	5	0	
Homosexuality	3	3	0	
Patients view of problem(chief complaint)				
Navy	31	10	0	+
Sex	23	2	0	▲
Family	20	6	0	
Days in hospital	20.3	15.9	0	

\*In not every instance was all the information available, and in some cases, the patient checked more than one answer.

+ = 0.1

‡ = 0.01

▲ = 0.001



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<p>The military physician is frequently confronted by patients who have made a suicide attempt. In an attempt to clarify the significance of these suicide attempts in the military, all patients who had made a suicide attempt in a nine-month period, and who were seen by the psychiatric staff of the U. S. Naval Aviation Medical Center, were retrospectively studied (N = 42). The suicide group was compared on 35 demographic, historical, and clinical variables to two control populations: 1) randomly selected psychiatric in-patients (N = 20) who did not make a suicide attempt; 2) well-adjusted enlisted men seen for administrative screening evaluations (N = 30). The suicide group and the psychiatric control group were followed 9 to 18 months after initial psychiatric contact. All data were statistically analyzed. From these data emerged statistically significant guidelines for the evaluation, treatment, and disposition of suicidal patients by the military psychiatrist.</p>		

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14. KEY WORDS	LINK A		LINK B		LINK C	
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